Field No.	Name	Entry

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To: Dental Providers
Managed Care Organizations

Memorandum No: 07-31
Issued: August 1, 2007

From: Douglas Porter, Assistant Secretary
Health and Recovery Services
Administration (HRSA)

For information contact
800.562.3022, option 2 or go to:
http://maa.dshs.wa.gov/contact/prucontact.asp

Supersedes # Memorandum: 06-40

Subject: Dental Program: Fee Schedule, Anesthesia Billing, Prior Authorization, and Coverage Changes

Retroactive to dates of service on and after July 1, 2007, the Health and Recovery Services Administration (HRSA) will implement:

- The use of 2007 relative value units (RVUs) for some dental services; and
- Rate changes as designated by the legislature for specific services within the dental program.

Effective for dates of service on and after August 1, 2007, the Health and Recovery Services Administration (HRSA) will implement:

- New billing standards for anesthesia;
- Rate changes for specific services;
- Coverage changes; and
- Prior authorization changes.

Maximum Allowable Fees

Retroactive to dates of service on and after July 1, 2007, HRSA is updating the Dental Program fee schedule by implementing the use of relative value units (RVUs) for some services. The new system will affect some rates within the dental program. In addition, the 2007 Washington State Legislature **appropriated additional funding for a vendor rate increase for certain services defined by specific CDT codes.**

Program/Service	Additional Funding
Access to Baby and Child Dentistry	$462,000
Orthodontic Services	$986,000
Crowns for Clients Through Age 20	$176,000

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Endodontic Services for: Clients Through Age 20 Clients Age 21 and Older	 $1,600,000 $1,800,000
Laboratory Fees for Dentures for Clients Age 21 and Older	$1,222,000

The maximum allowable fees have been adjusted to reflect these changes.

Visit HRSA's web site at http://maa.dshs.wa.gov/RBRVS/Index.html to view the new fee schedule, effective August 1, 2007. Bill HRSA your usual and customary charge.

Visit the Dental Program web site at: http://maa.dshs.wa.gov/ProvRel/Dental/Dental.html.

Anesthesia Billing Changes

Effective for dates of service on and after August 1, 2007, DSHS is adopting the American Dental Association (ADA) definition and coding for general anesthesia (D9220/D9221) and intravenous conscious sedation (D9241/D9242).

Bill for general anesthesia as follows:

Bill one unit of D9220 for the first 30 minutes of deep sedation/general anesthesia. Each additional 15 minute increment of deep sedation/general anesthesia is equal to one unit of D9221. **For example:** 60 minutes of general anesthesia would be billed as 1 unit of D9220 and 2 units of D9221.

Bill for intravenous conscious sedation/analgesia as follows:

Bill one unit of D9241 for the first 30 minutes of deep sedation/general anesthesia. Each additional 15 minute increment of intravenous conscious sedation/analgesia is equal to one unit of D9242. **For example:** 60 minutes of intravenous conscious sedation/analgesia would be billed as 1 unit of D9241 and 2 units of D9242.

Note: When billing for general anesthesia, show the beginning and ending times on the claim form in the "Description of Service" field on the ADA Claim Form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (e.g., when the patient can be safely placed under post-operative supervision).

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Coverage Changes

Effective for dates of service on and after August 1, 2007, HRSA now covers the following codes for dental providers:

Program	Procedure Code
Clients Through Age 20	D2952, D7270, D7310, and D7972
Clients Age 21 and Older	D2950, D3320, D3330, D3347, D3348, and D7972

Effective for dates of service on and after August 1, 2007, HRSA no longer covers the following codes for dental providers:

Program	Procedure Code
Clients Through Age 20	D5610, D5630, D5640, and D7320
Clients Age 21 and Older	D5610, D5630, D5640, and D7311

Prior Authorization (PA) Changes

Effective for dates of service on and after August 1, 2007, DSHS **no longer requires** PA for the following CDT codes:

Program	Procedure Code
Clients Through Age 20	D2931, D2933, D2950, D2952, and D2954

Effective for dates of service on and after August 1, 2007, DSHS **now requires** PA for the following CDT codes:

Program	Procedure Code
Clients Age 21 and Older	D2950, D3320, D3330, D3347, and D3348

Correction for ABCD ADA Claim Form Instructions

DSHS is updating and clarifying where ABCD services may be provided. Updated ADA claim form instructions are attached to this memorandum.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

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How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http:hrsa.dshs.wa.gov (clinic the Billing Instructions and Numbered Memorandum link). These may be downloaded and printed.

Field No.	Name	Entry
PATIENT COVERAGE INFORMATION (cont.)		
17a.	Employee/Subscriber Name (if Different from Patient's)	If different from the patient, enter the name of the subscriber.
17b.	Employee/Subscriber Dental Plan ID Number	If different from patient's, enter the subscriber's date of birth.
17c.	Employee/Subscriber Birthdate	Enter the subscriber's date of birth.
18.	Relationship to Patient	Check the applicable box.
BILLING DENTIST		
21.	Name of Billing Dentist, or Dental Entity	Enter the dentist's or dental entity's name.
22.	Address Where Payment should be Remitted	Enter the dentist's or dental entity's address.
23.	City, State, Zip	Enter the dentist's or dental entity's city, state, and zip code.
26.	Dentist's Phone Number	Enter the dentist's or dental entity's phone number.
28.	Place of Treatment	Check the applicable box and enter one of the following codes to show the place of service at which the service was performed: **Office** **11** dental office **Hosp** **22** outpatient hospital **24** professional services in an ambulatory surgery center **Other** **05** indian health service facility **06** indian health service facility **07** tribal 638 facility **08** tribal 638 facility **50** federally qualified health center

Field No.	Name	Entry
BILLING DENTIST (cont.)		
29.	Radiographs or Models Enclosed?	Do not send X-rays when billing for services.
30.	Is Treatment Result of Occupational Illness or Injury?	Check the appropriate box. If you check *yes*, enter brief description and dates.
31.	Is Treatment Result of an Auto Accident?	Check the appropriate box. If you check *yes*, enter brief description and dates.
32.	Other Accident?	Check the appropriate box. If you check *yes*, enter brief description and dates.
33.	If Prosthesis, is this Initial Placement?	Check the appropriate box. If you check *no*, enter reason for replacement.
34.	Date of Prior Placement?	Enter appropriate date if "yes" is check for field 33.
35.	Is Treatment for Orthodontics?	Check the appropriate box. If service already commenced, enter the date appliances placed and the months of treatment remaining.
36.	Identify Missing Teeth with an "x".	Place an "X" on the appropriate missing teeth.
Each service performed must be listed as a separate, complete one-line entry. **Each extraction or restoration** must be listed as a separate line entry. If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.		
37.	Examination and Treatment Plan	Follow instructions below:
	Tooth # or letter	Enter the appropriate tooth number or letter(s) 01 through 32 for permanent teeth A through T for primary teeth 51 through 82 or AS through TS for supernumerary teeth
	Surface	Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to **five codes** may be listed in this column: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal
	Description of service	Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending times.

1999 ADA Claim Form Instructions

Field No.	Name	Entry
HEADER INFORMATION		
2.	Prior Authorization #	Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.
3.-7.	Carrier Name, Address, City, State, and Zip	Enter the address for DSHS that is listed in the shaded box on page D.1.
PATIENT		
8.-11. 16	Patient Name (Last, First, Middle), Address, City, State, Zip Code	Enter the client's legal name, address, and **Patient Identification Code (PIC)**. HRSA identifies clients by this code, not by their name. This alphanumeric code is assigned to each HRSA client and consists of: • First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated). • Six-digit birthdate, consisting of numerals only (MMDDYY). • First five letters of the last name (or fewer if the name is less than five letters). • Alpha or numeric character (tiebreaker).
12.	Date of Birth (MM/DD/YYYY)	Enter the client's date of birth.
13.	Patient ID#	If you wish to use a medical record number, enter that number here.
17.	Relationship to Subscriber/Employee	Check the appropriate box.
SUBSCRIBER/EMPLOYEE		
19.	Subs./Emp. ID#/SSN#	Enter the SSN or other identifier assigned by the payer.
20.	Employer Name	Enter the name of the subscriber's employer.
21.	Group #	Enter the subscriber's group Plan or Policy Number.
22.-23. 25.-27.	Subscriber/Employee Name (Last, First, Middle), Address, City, State, Zip Code	If different from patient's (field 20), enter the legal name and address of the subscriber here.
28.	Date of Birth (MM/DD/YYYY)	If different from patient's, enter the subscriber's date of birth.

Field No.	Name	Entry
OTHER POLICIES		
31.	Is Patient Covered by Another Plan	Check the appropriate response.
32.	Policy #	If the client has third party coverage, enter the dental plan # of the subscriber.
33.	Other Subscriber's Name	If different from the patient, enter the name of the subscriber.
34.	Date of Birth (MM/DD/CCYY)	Enter the subscriber's date of birth.
36.	Plan/Program Name	Enter any other applicable third party insurance.
BILLING DENTIST		
42.	Name of Billing Dentist, or Dental Entity	Enter the dentist's or dental entity's name.
43.	Phone Number	Enter the dentist's or dental entity's phone number.
44.	Provider ID #	Enter your NPI here.
46.	Address Where Payment should be Remitted	Enter the dentist's or dental entity's address.
49.	Place of Treatment	Check the applicable box and enter one of the following codes to show the place of service at which the service was performed: **Office** **11** dental office **Hosp** **22** outpatient hospital **24** professional services in an ambulatory surgery center **Other** **05** indian health service facility **06** indian health service facility **07** tribal 638 facility **08** tribal 638 facility **50** federally qualified health center
50.-52.	City, State, Zip	Enter the dentist's or dental entity's city, state, and zip code.

Field No.	Name	Entry
ANCILLARY CLAIM/TREATMENT INFORMATION		
38.	Place of Treatment	Check the applicable box and enter one of the following codes to show the place of service at which the service was performed: **Office** **11** dental office **Hosp** **22** outpatient hospital **24** professional services in an ambulatory surgery center **Other** **05** indian health service facility **06** indian health service facility **07** tribal 638 facility **08** tribal 638 facility **50** federally qualified health center
39.	Number of Enclosures (00-99)	Check the appropriate box. **Note**: Do not send X-rays when billing for services.
40.	Is Treatment for Orthodontics?	Check appropriate box.
41.	Date Appliance Placed (MM/DD/CCYY)	This field ***must be completed*** for orthodontic treatment.
43.	Replacement of Prosthesis?	Check appropriate box. If "yes," enter reason for replacement in field 35 (Remarks).
44.	Date Prior Placement (MM/DD/CCYY)	Enter appropriate date if "yes" is check for field 43.
45.	Treatment Resulting from	Check appropriate box.
46.	Date of Accident (MM/DD/CCYY)	Enter date of accident.
BILLING DENTIST OR DENTAL ENTITY		
48.	Name, Address, City, State, Zip Code	Enter the dentist's name and address as recorded with HRSA.
49.	Provider ID	Enter your National Provider Identifier (NPI). It is this code by which providers are identified, not by provider name. **Without this number your claim will be denied.**
52.	Phone Number	Enter the billing dentist's phone number.

Field No.	Name	Entry
TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
54.	Provider ID	Enter the performing provider's NPI if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique NPI and/or name.
56.	Address, City, State, Zip Code	If different than field 48, enter the treating dentist's information here.
57.	Phone Number	If different from field 52, enter the treating dentist's phone number here.

Field No.	Name	Entry
ANCILLARY CLAIM/TREATMENT INFORMATION		
38.	Place of Treatment	Check the applicable box and enter one of the following codes to show the place of service at which the service was performed: **Office** **11** dental office **Hosp** **22** outpatient hospital **24** professional services in an ambulatory surgery center **Other** **05** indian health service facility **06** indian health service facility **07** tribal 638 facility **08** tribal 638 facility **50** federally qualified health center
39.	Number of Enclosures (00 to 99)	Check the appropriate box. **Note**: Do not send X-rays when billing for services.
40.	Is Treatment for Orthodontics?	Check appropriate box.
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46.	Date of Accident (MM/DD/CCYY)	Enter date of accident.
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56.	Address, City, State, Zip Code	If different than field 48, enter the treating dentist's information here.
57.	Phone Number	If different from field 52, enter the treating dentist's phone number here.